# Letters to the Editor

## Functional status questionnaires for spinal pain

The recent articles on the Oswestry Disability Questionnaire (ODQ) and Neck Disability Index (NDI) in the new Clinimetrics section of *AJP* provide constructive reviews of these commonly used disability questionnaires. There is no doubt that they have sound psychometric properties and are of practical utility in both research and clinical practice.

It is widely acknowledged that the best functional status questionnaires not only have sound test properties, but are quick and easy to administer and score (Beattie and Maher 1997). Patients in the clinical setting and participants in research trials quickly tire of filling out too many forms, and this can impact on compliance.

There is a relatively new functional status questionnaire, the Functional Rating Index (FRI), (Feise and Menke 2001) which overcomes these barriers to a large extent, yet has been largely unnoticed. In effect it is a hybrid instrument of the ODQ and NDI, consisting of 10 sections, with each item scored on a five-point scale. The key feature of the FRI is that it is a more clinician-friendly instrument, as it assesses both back and neck pain and requires only 78 seconds to be completed and scored. This compares with total administration times of 6 minutes for the ODQ (Davidson and Keating 2005) and 5–10 minutes for the NDQ (Sterling 2005).

The FRI has been shown to have above acceptable reliability (ICC = 0.99), internal consistency (Cronbach's alpha = 0.92), validity, and responsiveness (Feise and Menke 2001). Additionally, the FRI has higher responsiveness and reliability than the 18-item Roland-Morris Questionnaire (RMQ), another widely used back disability instrument (Chansirinukor et al 2004).

In summary, the FRI is an easy to use self report instrument that can be used to assess disability in patients with any spinal pain. It is psychometrically robust and significantly reduces administrative burden. There appears to be sufficient evidence to support the uptake of the FRI by clinicians and researchers.

**Julia Hush**
*University of Sydney*

### References

Beattie P and Maher C (1997): *Aust J Physiotherapy* 43: 29–38.

Chansirinukor W et al (2004): *Spine* 30: 141–145.

Davidson M and Keating J (2005): *Aust J Physiotherapy* 51: 270.

Feise R and Menke M (2001): *Spine* 26:78–87.

Sterling M (2005): *Aust J Physiotherapy* 51: 271.

## Indigenous health research needs to change focus

As an Indigenous Australian, and a physiotherapist, I found it very refreshing to see the Editorial on Indigenous Health Research in a issue of AJP (Cotter & Maher 2005). The issues raised are certainly relevant to Indigenous health and will hopefully generate new focus and discussion on this topic. However there is one important aspect which I feel has not been fully addressed—the perspective of Indigenous communities towards Indigenous health research. Specifically, there is a lack of outcomes for, and change in health status of, Indigenous Australians despite the amount of research that has already been undertaken.

While topics such as community control, ownership and empowerment, cultural appropriateness, and ethical responsibilities and guidelines have all been covered in the literature (Angus & Lea 1998, Humphrey 2001), linking research to outcomes for Indigenous communities seems to attract very little attention. Though there are examples in the literature where this has occurred (e.g. Mak et al 1998) this appears to be the exception rather than the rule. Consequently, the general perspective of Indigenous Australians is that continued research into the health and well-being of their communities is not only unnecessary (as many issues have already been identified) but also of little to no value (as previous research appears to have changed nothing). As such it is not uncommon for potential researchers to be rejected by Indigenous communities despite appearing to have the best of intentions.

To help change this perception and thereby progress in this area, it is my opinion that we need to rethink our primary objectives when considering research into Indigenous health. We need to understand that for Indigenous communities any research undertaken needs to result in a specific outcome being achieved, or at least progression towards that outcome. Our focus needs to shift from 'what do we want to know?' towards 'what do we want to achieve?' We know what the main issues in Indigenous health are—the challenge remains for us to ask ourselves what we're going to do about it.

If physiotherapy can approach Indigenous health research from this direction, I believe it will help us build strong partnerships with Indigenous communities and empower our profession to make real, positive changes in the health status of Indigenous Australians. In addition, we have an opportunity to become the standard by which other health professions approach the difficult, and sometimes overwhelming, issues affecting the health of Indigenous Australians.

**Ray Gates**
*Physiotherapist (Private Practice and Community Health Service)*

### References

Angus S and Lea T (1998): Planning for better health outcomes requires Indigenous perspective. *Australian and New Zealand Journal of Public Health* 22: 636–637.

Cotter P and Maher P (2005): Why the silence on Indigenous health? *Australian Journal of Physiotherapy* 51: 211–212.

Humphrey K (2001): Dirty questions: Indigenous health and 'Western research'. *Australian and New Zealand Journal of Public Health* 25: 197–202

Mak DB, D'Arcy C and Holman J (1998): Age at first episode of venereal syphilis in an Aboriginal population: An application of a survival analysis. *Australian and New Zealand Journal of Public Health* 22: 704–708.

## Correction to AJP Vol 51 No 4

There is an error in Figure 5 on page 248 of the article:

Wajon A and Ada L (2005): No difference between two splint and exercise regimens for people with osteoarthritis of the thumb: A randomised controlled trial. Australian Journal of Physiotherapy 51: 245–249.

The corrected Figure appears opposite.

The Editor apologises to the authors and to readers.

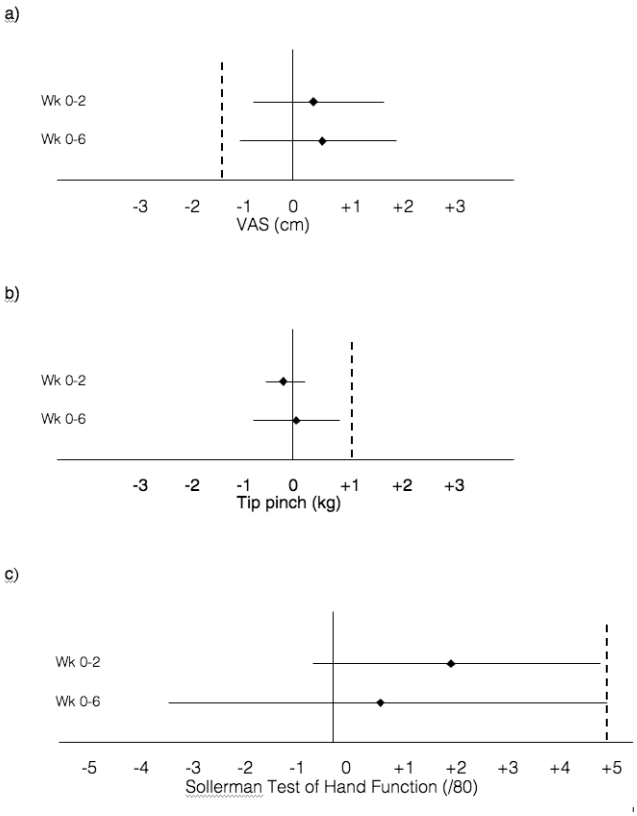


**Figure 5.** Size of effects (means and 95% confidence intervals) of experimental splint regimen compared to the control splint regimen. Nominally clinically significant effects are shown as dashed vertical lines. a), pain, b), strength, c), function.